Date: [Insert Date]

To:
[Receiving Physician/Gastroenterology Department Name]
[Facility Name]
[Address]
[City, State, Zip Code]

RE: Referral for Routine Colonoscopy Screening

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Patient Phone: [Patient Phone Number]
Insurance Provider: [Insurance Name/ID]

Dear Dr. [Recipient Last Name],

I am referring the above-named patient to your facility for a routine screening colonoscopy. The patient is currently [Age] years old and has reached the recommended age for colorectal cancer screening.

Clinical Indications:
- Average risk screening (Routine)
- Family history of colorectal cancer: [Yes/No]
- Previous colonoscopy: [None/Date of last procedure]

Relevant Medical History:
[List brief history or "None"]

Current Medications:
[List medications, specifically anticoagulants or antiplatelets]

Please contact the patient directly to schedule the procedure and provide instructions for the bowel preparation. Please forward a copy of the procedure report and pathology results to my office upon completion.

Thank you for your assistance in this patient's preventative care.

Sincerely,

[Your Name/Signature]
[Referring Provider Name]
[Practice Name]
[Phone Number]